NAIROBI, KENYA: CONGENITAL SYPHILIS PREVENTION PROJECT

Review of Project Design and Refinement
of Communications Component

August 3 - 27, 1992

Mona Moore
Health Communications Consultant
The Manoff Group/MotherCare Project

Report prepared for the
Agency for International Development
Contract #DPE-5966-Z-00-8083-00
Project #936-5966

ABBREVIATIONS

CBHW	Community-based Health Worker
CIDA	Canada International Development Agency
EEC	European Economic Community
HIV/AIDS	Human immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IEC	Information, Education, Communication
KABP	Knowledge, attitude, behavior and practice
MIS	Management Information System
MOH	Ministry of Health
NCC	Nairobi City Commission
PATH	Program for Appropriate Technology in Health
RPR	Rapid Plasma Reagin
STC	Special Treatment Clinic
STD	Sexually Transmitted Disease
TA	Technical Assistance
UoN	University of Nairobi
UoM	University of Manitoba
USAID	United States Agency for International Development

TABLE OF CONTENTS

Executive Summary.....1

I. Purpose of this TA Visit.....4

II. Project Background and Status.....5

III. Activities During this TA Visit.....9

IV. Summary, Conclusions and Recommendations.....20

V. Follow-Up Required.....26

Appendices:

Appendix A: List of Contacts
Appendix B: Report of Initial Screening/Treatment Data from Three Project Clinics
Appendix C: Revised Project Workplan
Appendix D: Draft Management Information System.
Appendix E: Guidelines for Clinic-Based Syphilis Education/ Counselling Content
Appendix F: Flowcharts of Syphilis Treatment/Education Provided by NCC and "Decentralized" Project Clinics
Appendix G: Social Marketing Workplan
Appendix H: Recommended Behaviors for Target Groups
Appendix I: Original Qualitative Research Plan Containing "Menu" of Topic Areas for STD Research
Appendix J: Revised Job Description/Counselling Coordinator
Appendix K: Training Protocols for Project Clinic Staff
Appendix L: Quality of Care at STC "Casino"

Executive Summary

This report describes the second MotherCare technical assistance visit to the one year Syphilis Prevention in Pregnancy project, being implemented by the Department of Microbiology, University of Nairobi, and closely linked to a larger CIDA-funded STD Control project based at the University of Nairobi Departments of Community Health and Microbiology. The project is being conducted at 10 of the 54 health units operated in periurban Nairobi by the Public Health Commission/Nairobi City Commission (NCC), where as many as one in fifteen routine antenatal attenders have tested positive for syphilis during the first months of project activity.

Mona Moore, Health Communications Consultant to The Manoff Group was originally sent to assist project staff with development of a detailed implementation plan for the communications component as outlined in the revised project proposal, with special focus on the design of the qualitative research phase. However, following initial discussions with recently hired local project staff and senior project supervisors, it became evident that review and revision of several key operational aspects of the project, such as strengthening the clinic model for providing services, were required before work on the communications component could proceed.

Activities accomplished during this TA visit therefore included working closely with project staff during the three week visit to strengthen the conceptual framework and details of implementation for the clinical aspects of the project; review, revise, and more completely document the baseline and routine information collection processes; and collaboratively develop a more appropriate IEC component for the project in light of the status of service delivery, with major focus on clinic-based syphilis education and counselling.

This detailed review of project design resulted in a request by senior project staff that significant changes be made in both the scope and content of the project as defined in the project proposal. The project may not be able to collect or report data on pregnancy outcome following treatment of maternal syphilis as originally proposed, due to budgetary constraints. In addition, the ambitious community based segment of the IEC component proposed to increase early antenatal care attendance will need to be phased in during the second half of the project year, after staff's clinical training in the ten project clinics has been completed and local project staff will have more time to devote to development of existing clinic-community linkages. As this report is written, discussion continues between MotherCare and project staff to resolve these issues.

Within the clinic based syphilis screening and treatment program, more attention will be given to developing a more effective

mechanism of partner tracing and treatment, one of the most essential components of STD control; and to provision of condoms along with post-diagnosis and partner counselling, to better enable couples to prevent reinfection after treatment.

The revised IEC component will initially be limited to development of print materials for clinic-based syphilis education and counselling for clients, and strengthening syphilis counselling skills of clinic workers, to reflect the changes proposed in the overall project design. Community-level IEC materials can be developed later if community based health worker (CBHW) activities are phased in during the second half of the project year, and clinical services maintain a predetermined standard of quality.

A smaller scale qualitative research component is scheduled to begin in October 1992, which will be limited to interviews with women recently diagnosed with syphilis and their partners, to explore their experiences with the disease and compliance with recommended behaviors; and interviews to determine syphilis related knowledge, attitudes and practice of staff in project clinics. A resident anthropologist has been tentatively identified to coordinate and implement the research, and was thoroughly briefed in the health-technical and social marketing aspects of the research by this consultant.

The local IEC Coordinator staff position has been redesignated as Counselling Coordinator, which better reflects the qualifications and experience of the individual chosen for the position, and meets the immediate clinic-based counselling training needs of the project. It is recommended that MotherCare/Manoff IEC consultants provide as much (and sustained) technical assistance as possible to the project.

It is also recommended that the next external MotherCare IEC TA be rescheduled for January - February 1993, when two consultants should overlap to provide coordinated development of 1) the refinement of the clinic staff counselling training module and implementation of that training, and 2) the pretesting and production of draft IEC print materials for clinic-based counselling, and training of clinic staff in materials use.

Due to the amount of consultant time devoted to review of the clinical aspects of the project during this visit, the continued difficulties locating an affordable, qualified local IEC consultant in-country, and the possibility of further revisions in the overall project design and budget for IEC activities as MotherCare and senior project staff continue to discuss proposed changes, a final plan for the qualitative research could not be developed with project staff in country as originally planned. A revised qualitative research plan and detailed question guides to accompany the proposed revision in research objectives still need to be developed, after further MotherCare review of the project design

and budget determines funds available for a revised IEC component.

Although the activities which took place as part of this technical assistance visit were extremely different than the IEC-specific TA originally planned, it provided a timely and much needed opportunity for the entire team to review and revise the proposed project design. As a result of this extensive team review, a more appropriate, achievable project design has been suggested. The IEC component will be redesigned to reflect the local staff, time and financial resources available.

Project training and data collection activities already underway have been strengthened by the more clearly defined detailed implementation plan and revised reporting methods developed collaboratively during this visit. The systems which can potentially be developed and documented by this project could help to standardize, disseminate and replicate knowledge about improved operational aspects of maternal and neonatal syphilis control in the developing world, as well as produce a model for state-of-the-art syphilis IEC materials developed through use of the behavior change approach.

I. Purpose of This TA Visit

In April 1992, Senior Communications Advisor for the MotherCare Project, Kim Winnard, made a technical assistance visit to Kenya to assist Dr. Marleen Temmerman and others in the Department of Medical Microbiology/ Department of Community Health at the University of Nairobi with refinement of a project proposal to strengthen congenital syphilis prevention activities at several government health clinics in the capital city, Nairobi. Key programmatic changes in the project design as a result of that visit include 1) expansion in number of neighborhood health clinics involved from 3 to 10, increasing the population served from 180,000 to 600,000 and 2) expansion of the scope and content of the project's IEC component, including greater attention to qualitative research, the development of materials to support and improve counselling skills of STD/antenatal care health workers, and motivational/educational materials for clinic attenders. Further details of that visit, the refined project proposal, and background materials on the current STD control program and activities in Kenya are included in Winnard's Kenya trip report.

This report describes the technical assistance visit to the project by Mona Moore, Health Communications Consultant to The Manoff Group. The original purpose of this TA visit was to assist project staff to revise, if necessary, the overall project workplan, and to develop a detailed implementation plan for the communications component as described in the revised project proposal, with special focus on the design of the qualitative research phase.

However, following initial discussions with project supervisors and recently hired project staff, it became evident that review of several additional service delivery aspects of the project were required before work on the communications component could proceed. Activities accomplished during this TA visit therefore included working closely with project staff during the three week visit to:

1) review proposed project activities and timeframe; develop more realistic project design; revise the project workplan to reflect changes in content and scope;

2) review and redesign baseline assessment instruments; review and modify other project data collection activities; develop draft management information system (MIS) to systematize documentation; discuss possible indicators of effectiveness of project activities, especially IEC activities;

3) review training materials being developed and used by the larger STD project; review and document content/protocols for STD screening and counselling being used to train staff in project clinics;

4) discuss the components of comprehensive primary level STD care and counselling; especially the importance of partner tracing in syphilis prevention, and strengthen plans for this component of care in project clinics; discuss development of a quality of care "checklist" for STD/antenatal care and counselling based on the revised instrument for baseline data collection at project clinics;

5) review the steps in a social marketing/behavior change approach to developing a project communications strategy, and produce a revised workplan for the project IEC component;

6) design a qualitative research plan and develop an IEC workplan/schedule; conduct in- depth review for local project staff in basics of qualitative research techniques (focussed group discussions and depth interviews, methods for analysis of results, content and format of research report); identify local consultant to conduct and coordinate qualitative research;

7) formulate a draft outline for content of health education sessions and post- diagnosis syphilis counselling to be used at project clinics until IEC materials are developed;

8) review existing STD counselling training materials; attend counselling materials development workshop; discuss plans for refresher training for clinic staff, especially use of IEC materials and interpersonal/ counseling skills training sessions;

9) locate and interview artist/graphic designer for design and production of IEC materials; outline plan of work for materials production and obtain costs estimate;

10) review MotherCare project/ AID reporting requirements and trip report review process.

Although this TA visit was originally planned to focus specifically on development of the communications component, other project activities were extensively reviewed and revised. These other activities are detailed here because of the level of team effort which was required during this visit to review and revise them, and to serve as a document of record for local project staff.

II. Project Background and Status

The revised project proposal contained the following intervention and research objectives:

- to increase early antenatal attendance at project clinics (prior to 20 weeks gestation) from 25% to 80%;
- to increase percentage of antenatal patients screened for syphilis from 50% to 90%;
- to increase percentage of RPR+ antenatal patients receiving correct treatment from 30% to 100%;
- to improve number/rate of partner treatment from (no specific targets identified);
- to increase number of neonates with actual/suspected congenital syphilis detected and correctly treated (no targets specified);
- to investigate underlying factors which influence health seeking behavior during pregnancy in pregnant women and partners; and factors which influence provision of antenatal/STD health care by clinic and community health workers;
- to document changes in maternal/fetal syphilis transmission rate by gestational age at treatment; determine feasibility and cost/benefit analysis of repeat RPR during third trimester in previously negative antenatal patients, to detect late infection (it is not possible in this project setting to determine/distinguish reinfection);
- to document replicability, sustainability and cost/effectiveness of overall pilot congenital syphilis prevention project.

The project to reduce the incidence of congenital syphilis will be conducted at 10 of the 54 health units operated in periurban Nairobi by the Public Health Commission/Nairobi City Commission (NCC). Three of the ten clinics are research sites for the CIDA funded Strengthening STD Control in Primary Care Facilities project which began in 1990.

Maternal syphilis infection has recently been demonstrated in approximately 1 of every 20 women attending antenatal clinics in the project area (peri urban Nairobi). Pregnancy outcome is improved, and serious sequelae such as miscarriage, stillbirth, and congenital malformations, decrease if women with syphilis are detected and treated as early in pregnancy as possible, preferably in the first trimester. Although antenatal care coverage in Nairobi is high (90% of women make at least one clinic visit during pregnancy), more than half of antenatal attenders do not present for care until the third trimester of pregnancy. Quality of the syphilis screening component of routine antenatal care at NCC

clinics is variable; in a 1987 study, less than 10% of recently delivered mothers at the maternity referral hospital had a syphilis test result recorded on their antenatal card.

Since publication of National guidelines for STD Control by the Kenyan Ministry of Health in 1990, several gaps between recommendations and actual implementation of the screening and treatment procedures have been identified. The problems include supply, logistics and transport of essential STD medications: inadequacies in screening, diagnosis and treatment of STDs, and in tracking and treatment of partners by providers at the clinic and referral center level; and late antenatal care attendance, poor compliance with treatment referral and partner notification requests among pregnant women. Among many efforts to reduce the gap, the CIDA project is training staff, developing clinical diagnostic and treatment protocols and designing promotion and prevention strategies at three NCC clinics (Dandorra, Kariobangi and Baba ndogo).

The European Economic Community (EEC) is supporting improved STD service delivery at the Special Treatment Clinic (STC), the referral center for all STD cases in the Nairobi public health system through a variety of mechanisms. The STC, also popularly referred to as "Casino", is staffed by three clinical officers, and provides STD treatment to as many as 750 patients daily.

Based on the combined experience of the projects described above, this project was designed to test four key strategies:

- decentralization of STD diagnosis and treatment (to relieve some of the congestion at the STD referral clinic and increase access to and use of care);
- increased focus on maternal and congenital syphilis;
- improved ability of primary health workers to deliver comprehensive, quality STD care; and
- education and mobilization of the community of pregnant women to increase their early antenatal attendance and compliance with STD care.

The project officially started on June 1, 1992, following notification of the completion of the AID contract approval process. Project progress to date includes implementation of the following activities planned for the first project quarter:

Staffing:

The project director/principal investigator, Dr. Francoise Jenniskens, has replaced Dr. Marleen Temmerman who left Kenya June 1992. Dr. Jenniskens is currently completing her dissertation for the London School of Tropical Medicine and Hygiene (based on her recent work assessing quality of STD care at STC in Nairobi) and will assume her role in the

project in early October. Her projected level of effort is 20% time. She is also supervising at least two other EEC-supported operations research projects on STDs in pregnancy.

Three key full-time national staff have been hired:

- Project Field Coordinator: Dr. Emily Obwaka, a dentist who recently completed her MPH at University of Nairobi;
- Counselling Coordinator (who was originally designated as IEC Coordinator, but whose roles and responsibilities were redefined during this TA visit): Mrs. Sarah Kirisua, a teacher with counselling and womens group experience;
- Laboratory Technician: Mr. Michael Kitabu.

A recently graduated nurse/midwife, Ms. Eunice Adhiambo, has also been hired on a part-time temporary basis, primarily on baseline clinical data collection. (Her salary is currently being drawn from the local consultant budget line).

Supplies and equipment:

Supplies and equipment have been distributed and initial training has been completed in the three project clinics which have had ongoing involvement with the larger STD project (Dandora, Langata, and Kariobangi). Initial training includes an overview of the process of antenatal syphilis screening, RPR techniques and a brief overview of counselling skills for clinic staff. Further description of current clinic training content is included in Section III. of this report under Training, and as Appendix K.

Staff activities:

The project field coordinator has also made initial site visits to introduce the project and conducted a brief orientation at Baba ndogo, Ngong Road and Kangemi clinics. Similar initial staff training will be carried out next at these clinics, but it will be more in-depth as these clinics have not participated in the STD control activities related to the larger project.

The (newly designated) Counselling Coordinator has conducted a brief overview of counselling techniques as part of the initial training for clinic staff mentioned above. She has also conducted a group discussion among pregnant women at Baba ndogo clinic, and two group discussions among community based health workers (CBHWs) at a recent two week CBHW training session. Results of these initial FGDs have provided interesting and informative background information about these two target groups, and will guide development of expanded

research instruments for the revised qualitative research effort.

Toward the end of this TA visit, project and NCC Department of Health decisionmakers completed the selection process for the remaining project clinic sites. The revised project sites are:

- o Dandora
- o Kariobangi
- o Langata
- o Ngong Road
- o Riruta
- o Kangemi
- o Baba Ndogo
- o Ngara
- o Jericho
- o Mathari North

Data collection:

Collection of baseline antenatal/STD service provision data from the clinic sites has begun. Two initial clinic assessments have been completed. Information contained in the initial reports was used to expand and redesign a more comprehensive baseline assessment instrument which will be used in the remaining project clinics. It is planned that this redesigned baseline quality of care assessment instrument will be further developed over the life of the project to provide a "checklist" for standardized measurement of quality STD/ antenatal care.

Data recently collected from the three project clinics which have completed initial training delivered by local project staff is attached as Appendix B. The number of RPR+ women treated is lowest at Langata Clinic (50%), as is the number of partners treated. Partner treatment appears to be a problem at Dandora as well; full partner treatment was achieved at Kariobangi, where the nurse-in-charge witholds the patient's antenatal card (required for admission to hospital for childbirth) until the partner attends clinic for treatment.

IEC related activities (design of qualitative research and counselling training module) did not begin in June as originally planned; detailed planning for these activities is taking place as part of this TA visit.

III. Activities During this TA Visit

Following initial review of the overall project design, it became evident that several aspects of the clinic-based service delivery component of the project would need to be reviewed and revised before the IEC component could be developed. Therefore, during this TA visit, the consultant and project staff worked closely together

to review the entire project design, rather than solely the IEC component. This section provides a detailed description of the joint team project review activities, primarily to document the day- to- day decisions made.

Review of Project Design

Initial discussions between the IEC consultant and local project staff during the first weeks of the visit identified several issues related to baseline data collection and project implementation which did not appear to be adequately defined or documented. Upon arrival of Dr. Marlene Temmerman (11 days after start of the 18 day consultancy), the entire staff met to discuss these issues in depth. As a result of those discussions major discrepancies were identified between the language contained in the project proposal/contractual statement of work and the understanding of proposed project activities among senior project staff. Major changes which would be required to reallign proposed project activities with human and financial resources available to the project through MotherCare funding were outlined.

Because of the magnitude of the suggested changes and the need to verify the acceptability of the changes to decisionmakers within the MotherCare project and at AID, Dr. Temmerman communicated directly with Dr. Koblinsky during this TA visit, and the proposed changes in project scope, content, and data collection are still being discussed. Local project staff, however, proceeded with planning for implementation of project activities assuming approval of the suggested changes. The major changes suggested in the project design as it is currently reflected in the contract/statement of work are:

a) Research objective #2 : to study maternal-fetal syphilis transmission rate as function of gestational age at treatment. This would require follow up of RPR+ women throughout labor and delivery, so that postpartum neonatal RPR status could be documented. Although this remains a major research interest of the local team, their understanding was that it had been deleted, as the MotherCare project was more interested in the IEC aspects of the project. As the originally proposed project budget for solely the research aspects of the project was halfed by MotherCare, while at the same time proposed project clinic sites were tripled and a major IEC component was added, senior project staff feel that it is impossible to provide MotherCare with data requiring aggressive tracking of antenatal patients through labor, and 24 hour delivery room/postpartum ward monitoring within the current budgetary allocation.

b) The proposed IEC component and related IEC/ behavior change objectives as reflected in the revised proposal (for example,

improving dramatically current rates of early antenatal care attendance among women in all ten clinic catchment areas to facilitate assessment of effects of timing of syphilis treatment on pregnancy outcome) assumes implementation of a level of community based education/motivation activities which would be difficult to assure within the project's one year timeframe through the existing community based health worker (CBHW) network. Although in many of the clinic catchment areas, a CBHW system exists, in most areas the CBHW network would need to be further defined, organized and strengthened. Senior project staff feel that it would be difficult to provide the local staff time required for timely development of the proposed community component with current staffing constraints without compromising the clinic-based staff training for syphilis screening and treatment which is the foundation for the proposed community work.

Options discussed at length were 1) reducing the number of clinic sites but maintaining the community component in catchment areas where this was already most well developed, 2) eliminating the community level of activities altogether to allow focus on well developed clinic-based education/counselling and eliminate the need for developing and achieving indicators for success at community level and 3) phasing in the community level activities, beginning in the second half of the project year, after initial and refresher clinical training had been completed, and clinic-based IEC materials had been produced.

Senior project staff prefer the third option, phased community activities, and are continuing to think of alternative ways to begin promotion of earlier antenatal attendance, which is prerequisite to obtaining meaningful data on pregnancy outcome according to gestational age at time of syphilis treatment. Alternative means of promoting/facilitating increased partner treatment compliance in the absence of large scale community level IEC activities will also need to be developed.

The project workplan has been revised to reflect these significant changes, and is attached as Appendix C.

Management Information System

Project staff had completed initial collection of some baseline information in two clinics using preliminary guidelines provided by Dr. Temmerman prior to her departure. Two week periods of clinic-based observation and data collection are required per clinic under the current system. These procedures were reviewed in detail with local staff to assure that the three types of information which are needed are being collected: 1) baseline data on clinic service statistics, staffing patterns, and overall

content, organization and provision of care (antenatal services are not delivered separately from other clinic services, but are offered daily as part of an "integrated service delivery" design; 2) baseline information on attendance levels and management of all antenatal patients; and 3) special information on diagnosis and management of RPR+ women diagnosed through antenatal syphilis screening.

Detailed review of this information collection process indicated that the most complete of the required information being collected was the information on RPR+ women. Project staff jointly developed expanded guidelines for the other areas of information collection, especially for IEC-realted baseline assessment of content and process of current health education of antenatal clinic attenders and counselling of RPR+ women and their partners. Questions were also added to explore existing clinic-community health worker linkages. Local project staff will incorporate these additional items and others related to quality of antenatal/STD care into a revised format. The consultant strongly urged local project staff to further develop the revised baseline assessment to create an "Antenatal STD Quality of Care Assessment Instrument" which could facilitate standardized, comprehensive assessment of each required component of maternal syphilis prevention and control efforts.

As part of this review process, a draft management information system (MIS) was developed which lists required information, methods of information collection and possible indicators of effectiveness for each intervention, research and behavioral project objective (See Appendix D). Although very basic, this created a more systematic approach to documentation of baseline and routine data collection.

Most of the indicators of effectiveness suggested in this MIS are process indicators, and are well within current project data collection capabilities. The mechanism for data collection and recording for outcome indicators, especially for the more complex research objectives, will need to be further developed. Achievement of many of the behavioral objectives would require community level project activities; further discussion of these was therefore deferred until decisions regarding the shape of that component of the project are finalized.

Training

As mentioned earlier, local project staff had completed initial training in two project clinics, using guidelines for content and process adapted from the larger STD control project. Clinical training in syphilis diagnosis by clinical and laboratory findings, RPR techniques and counselling are main objectives of the initial training, which is conducted in two week cycles. As there are eight sets of clinic staff still to be trained, it is expected that training will continue until late November or early December. The

protocols for this training have now been formalized and documented (Appendix K).

The consultant also reviewed most of the training materials produced and currently used by the larger UoN/UoM STD Control project. That training is extensive, covering the entire range of STDs. The syphilis- specific IEC training and materials which will be developed as part of the MotherCare project can easily expand upon and be incorporated into the larger project's STD training without duplicating existing efforts.

Although there was not adequate time during this TA visit to allow for detailed discussion of the larger project's STD training materials, time should be allocated in future TA visits for more extensive joint review of these materials and possible collaboration on refinement of those materials.

Work is currently in progress to develop the final format for the counselling module of the larger STD training. This is discussed further under TA activity #9 below. To strengthen the MothreCare project's current counselling component prior to completion of the syphilis counselling module and materials, a list of topics to be included in the project clinic's antenatal education sessions and RPR+ counselling was developed for interim use by the counselling coordinator in her daily syphilis counselling/education training activities (Appendix E).

Service Provision

The entire project staff systematically reviewed current plans for implementation of each component of the clinic-based syphilis screening, treatment and prevention activities. Proposed actions and specific language used in the proposal were examined.
The discussion was extremely helpful for all of us, and many technical areas were defined, clarified, or expanded. Several areas were identified which needed strengthening and further development.

For example, partner referral and treatment has been identified in the international STD literature as an area of STD control most in need of " more investment in ... careful documentation of the efficacy of alternative strategies", and this could therefore be an important contribution of this project to existing knowledge. A detailed process was developed for encouraging partner attendance, providing services to partners who do attend, and agressive tracing and treatment of partner defaulters (which will be called "assisted compliance"). Project recordkeeping will be revised to separate out those partners treated who complied spontaneously, and those who required "assistance".

Another area of service provision reviewed and strengthened is

attempted prevention of reinfection of RPR+ women treated at the project clinics. Previous studies on condom use in Kenya indicate problems in acceptance of condom use, and lack of knowledge at the community level about where to obtain condoms (this will hopefully decrease with the recent media launch of the USAID-funded condom social marketing campaign).

Experience in other behavior change programs has proved that enabling target groups to adopt behaviors by increasing access to the recommended product (in this case condoms) increases at least trial of the recommended behavior. Enabling RPR+ women to negotiate condom use with their partner(s) is particularly important in the setting of this project, as the syphilis laboratory screening method currently used (RPR cards) cannot detect reinfection in the short interval between diagnosis in late pregnancy and birth.

Appendix F contains two flowcharts developed by the consultant during the detailed review of clinical service provision. These charts utilize the "flowchart" format used in the larger project's STD clinical training. The first flowchart compares the streamlined, decentralized syphilis control process in project clinics to the current system in other NCC clinics. The multitude of opportunities for patient non-compliance in the current system are clearly represented. The second flowchart systematically outlines each step in the project's planned activities, and describes in detail complete management of the syphilis patient in a step by step manner. Each potential opportunity for education/counselling is indicated, and the required support materials for each "point of contact" are outlined, thus graphically depicting the project's IEC activities and IEC material development needs.

These flowcharts will be incorporated into the remaining training for project clinic staff, and could also be useful for orientation of future IEC consultants, or other external project observers.

After final determination of the revised scope and content of overall project activities, attention turned to the IEC component.

IEC Training for Local Project Staff

Because the local project staff has not had extensive prior experience with IEC, much time early in the visit was devoted to a review of the basic concepts behind the social marketing/behavior change approach to development of communications strategies and materials. A generic social marketing workplan was reviewed, and the steps in the social marketing process were discussed to provide local staff with an overview and perspective about how the upcoming research would contribute to the materials development phase and other aspects of the project. The revised project social marketing workplan which was developed is attached as Appendix G.

As an initial activity in discussion of the behavior change approach to IEC materials development, a list of recommended behaviors required to achieve project objectives was generated for each target group - pregnant women, clinic and community based health workers, and male partners (Appendix H). Additionally, a comprehensive qualitative research plan and a "menu" of potential topic areas for exploring the multitude of underlying factors related to syphilis transmission, screening, treatment, and community education were developed (Appendix I). From the comprehensive lists, project staff selected the most essential topics and target groups which will be developed into a revised research plan after decisions regarding possible revisions in the project are finalized. This revised research plan and detailed question guides reflecting any changes in overall project design will need to be developed in Washington by the consultant or other Manoff consultant in early September.

Because the level of preparation required to orient local project staff to the qualitative research process was not anticipated by the consultant, a full set of materials usually used for training on focus group techniques, qualitative methods, etc. was not available to leave with local staff, and should be supplied at a later date. However, an overview of techniques and methods was provided, including projective techniques; developing a lexicon of terms for exploring women's reproductive health issues; the concept of motivational appeal in message development and types of research questioning required to support it; eliciting verbatims and "testimonials"; developing case histories; and methods of analysis of qualitative data.

Existing Information on STD/Syphilis KABP

Local project staff have worked in the clinics on a daily basis since the project began and already have formed strong personal impressions and gathered important information about clinic workers and CBHWs knowledge, attitude and practice as related to STDs and syphilis. Both project clinic workers, and CBHWs from East and West Nairobi who attended a recent training seminar have minimal knowledge of the basic factual information about signs, symptoms, sequelae, treatment or prevention for STDs in general, but even less about what is required for syphilis detection and control (with the exception of the two clinics which have received the training course from the larger STD project, where general STD knowledge is higher). It is anticipated that clinic attenders and community members will have correspondingly low knowledge levels.

Initial discussions with antenatal attenders verified that Kenyan women postpone antenatal attendance for many of the same reasons that women in most developing nations do - because they think it is not necessary to come for care earlier, because early attenders are frequently sent away by care providers, and because if they have completed one successful pregnancy, they have less anxiety

about those which follow. Reasons why women do attend antenatal care include desire for tetanus toxoid immunization, and to obtain the antenatal card which is prerequisite for delivery at Pumwani Maternity Hospital or other maternity centers.

In addition to preliminary information collected by local project staff, the larger STD study has completed at least two KABP studies. Much emphasis has been placed on AIDS education in Kenya in recent years, and according to the STD project quantitative studies and PATH STD focus group results reviewed, awareness of HIV/AIDS and "safer sex" behaviors is relatively high. Knowledge of other STDs and adoption of preventive behaviors among those groups was predictably less.

Identification of Local IEC Technical Assistance

The IEC component described in the revised project proposal relied heavily on identification of a highly qualified local IEC Coordinator, and periodic use of local consultants to supplement the IEC skills of the local project staff. Locating appropriate IEC core staff and IEC consultants locally within current budgetary allocations (also determined by the UoN salary scales) had been difficult and time consuming for senior project staff, and continued to challenge this consultant. The "IEC environment" in Nairobi is extremely well developed and competitive; many international organizations are competing for relatively few experienced IEC consultants who have become accustomed to working at international rather than local salary scale. The salary currently allocated for the local IEC consultant would need to be multiplied by as much as ten in order to recruit someone with the qualifications in the job description developed by MotherCare for project IEC coordinator (Masters-level communications education and 5 years IEC field experience). As the person hired in the IEC Coordinator slot does not have the requisite IEC background or experience, several other potential candidates were interviewed during this TA visit; salary requirements were consistently as high as those of many international IEC consultants.

Because it is essential that the qualitative research begin as soon as possible so as not to further delay materials development, preliminary arrangement has been made with an American-born anthropologist, a long time resident of Nairobi and fluent in Kiswahili, to coordinate and implement only the qualitative research phase of IEC activities. However, this will require use of almost all of the currently allocated budget for local TA of any type required by the project.

Unless more experienced, less expensive local IEC consultants are identified, it may be best if additional periodic IEC TA is provided by external MotherCare consultants, rather than by local consultants as originally planned. Discussion will continue in Washington following this TA visit to confirm possible reallocation

of the existing IEC budget, to determine additional resources required, and assess whether there is need of or resources for additional local IEC TA. A new job title and description (Counselling Coordinator) has been developed for the local project staff member initially hired as IEC Coordinator, which better reflects her skills and experience, and which more closely reflects immediate project needs to support clinic-based syphilis education/counselling (Appendix J). She will also have primary day to day responsibility for the expanded partner tracing/treatment activities.

The local IEC consultant tentatively identified to coordinate and implement the qualitative research, Dr. Donna Klumpp-Pido, was not in country during this TA visit. However, local project staff have been prepared to brief her on project details, a comprehensive orientation packet has been prepared for her, and MotherCare has provided additional IEC-technical briefing in Washington.

If the revised scope of the project and the IEC component are approved, it is expected that the consultant will begin work in Nairobi approximately October 1, slightly later than planned, but still in time to allow for development of draft IEC materials for use in the clinic staff refresher training planned for February 1993. Additional details of the scope of work and timeframe for the local Qualitative Research Coordinator TA will be finalized after MotherCare project/budget review is completed during the first two weeks of September.

Qualitative research results will be combined with existing STD/syphilis KABP information to design IEC messages and materials for clinic-based education of antenatal patients and counselling RPR-positive women and their partners. It is anticipated that draft materials will be available in February 1993, to coincide with the planned refresher training course.

Review of Existing IEC and Counselling Materials

PATH has nearly completed development of a set of STD counselling materials for use in STD treatment clinics. Two separate six-poster sets, for male and female audiences, contain basic messages : Discuss STDs; Preventing STDs is Possible; Anyone can have STDs; Use Condoms/Limit Sexual Partners; Adopt Safer Sexual Behaviors - Feel Healthy, Feel Good. A manual for educators contains more detailed information to accompany the flipchart set. These will be available for purchase in late September, and should be useful to strengthen current education sessions for clients at project clinics.

The development and production of a syphilis-specific counselling module is one of the major components of the project's planned IEC activities. This module will be used for training of project clinic staff in both the process and content of post-counselling RPR+

patients and their partners, and to improve their overall interpersonal communication skills.

The larger STD project is currently developing an STD counselling module, under the direction of Dr. Elizabeth Ngugi, Co-Director of the CIDA funded STD Control project, based at the Department of Community Health/UoN. This consultant had the opportunity to attend portions of a three day workshop August 17-19, designed to review existing materials and the STD Control project's counselling experience to date, and develop a comprehensive final STD Control project counselling module.

The importance of incorporating materials for this project into these larger IEC and counselling efforts should not be overlooked. Development of materials for the project which contain messages and information specific to syphilis will enhance existing materials without duplication.

Locate Artist and Obtain IEC Production Cost Estimates

The consultant met at length with the artist who worked on the PATH materials, Mr. Emanuel Kariuki, to discuss the possibility of collaboration on development of this project's IEC materials. Mr. Kariuki is a young, independent consultant in graphics/materials design who participated actively in much of the PATH materials pretest process, and modified his original drawings accordingly. His next assignment is pretesting STD-related materials for prostitutes in Mombassa. This experience potentially reduces the amount of orientation which would be required for the artist on the overall area of STD materials; instead, discussions could focus on the particular materials development needs of our project. In addition, use of similar but slightly more specific images might contribute to continuity with existing materials.

Based on a brief description of the type and amounts of IEC materials this project may produce (including laminated four color "counselling cards" for clinic use, and black and white paper leaflets with corresponding images and slightly simplified messages), the graphic designer provided a realistic, affordable estimate of costs which is well within the present IEC budget.

We agreed that a good approach would be to use color xerox reproductions of original drawings, cased in plastic folders, as draft materials to be prestested at the clinic staff refresher training in February 1993. After additional pretesting in the community, these draft materials could be revised and produced in final form directly following the training session.

If these cost estimates are approved as part of the upcoming

project budget review by Mothercare staff, Mr. Kariuki should be contracted as soon as possible, to assure that the artist will be able to commit the required time to overlap with the next proposed IEC materials development TA visit in January - February, 1993.

Review of Local Staff Responsibilities/Schedules and MotherCare Reporting Requirements

During final planning meetings, local project staff were provided with calendars for the upcoming quarter, and developed detailed "personal action plans" based on realistic division of roles and responsibilities for tasks required during this time period.

The quarterly progress report which must be submitted was discussed with local project staff, and the process for review of MotherCare trip reports was reviewed. Copies of all future trip reports related to the IEC component should be provided to local staff as well as the PI, as they are closely involved in implementing many of the activities. Dr. Temmerman also requests that MotherCare send her copies in Belgium if this is possible so that she can remain informed about developments in the project. Dr. Ngugi should also be advised of final IEC and counselling materials development plans for this project, as they parallel those of the STD project she directs.

IV. Summary, Conclusions and Recommendations

At the time when this IEC TA visit was planned and conducted, this project to detect maternal syphilis and prevent congenital syphilis intended to achieve the research, intervention and behavior change objectives defined in the project proposal through three major components: 1) service delivery to decentralize and increase pregnant womens access to syphilis diagnosis and treatment, 2) training of clinic staff to improve effectiveness of syphilis diagnosis, treatment and counselling , and 3) IEC activities, both to support clinic based education and counselling and to develop community level syphilis education and motivation for earlier antenatal clinic attendance.

Initial consultant debriefing with AID representatives in Washington has clarified some of the emerging donor priorities and possible changes in project structure and budget which may be made to accommodate them. This information was not readily available while in Kenya, and strongly influences consultant recommendations for the scope and content of the project's IEC component. In addition, discussions with MotherCare and Manoff staff have helped to clarify and consolidate the presentation of the findings and recommendations resulting from this TA visit. The following recommendations reflect this additional information and consultation.

1. Change Focus of IEC to Clinic-Based Setting

The clinic-based service delivery aspects of this project (syphilis screening, treatment, counselling and partner treatment) are the foundation on which both the success of the community component and the design, scope and content of the IEC activities depend. By necessity, much of this TA visit was devoted to reviewing and refining clinical care and initial clinic staff training procedures. The appendices attached demonstrate the considerable progress which was made to clarify and strengthen the implementation and documentation of these aspects during the TA visit.

Because the resources available to similarly develop and support the community component are in question, focus should shift to developing IEC materials and methods for use in the clinic setting.

This will still include design and production of IEC materials (counselling cards, partner notification cards, etc) based on qualitative research as originally planned, and developing a syphilis counselling training module and materials for clinic health providers.

2. Reduce the Scope of the Qualitative Research

However, the scope and content of the qualitative research will be reduced to reflect the de-emphasis of community-based activities which is currently proposed. The research will now focus specifically on a) investigating barriers, resistances and motivating factors among pregnant women with syphilis and their partners; b) determining the amenability to change current unsafe sexual behaviors and practices; and c) exploring the factors which contribute to ineffective syphilis screening, care and counselling among health care providers in the 10 project clinics.

Manoff/MotherCare should allocate additional TA time and locate staff or consultant to complete the revised research plan and accompanying question guides which cannot be completed until larger project design and budget questions are resolved.

3. Shift the IEC Related Responsibilities to External Consultants

The nature of the qualitative research requires strong cultural familiarity and Kiswahili language ability to be maximally effective. The remainder of steps in the development of clinic IEC materials and counselling training require in-depth understanding and considerable experience and expertise in use of the behavior change approach and creative social marketing techniques not widely available in Kenya.

Therefore, with the exception of the local source of TA tentatively identified as the qualitative research coordinator, future IEC TA should be provided by external MotherCare/Manoff consultants at critical points in the IEC component where such expertise is required. This is especially important due to the project's relatively short duration, limited budget for IEC activities, and need to provide substantial and sustained technical assistance to local project staff. These challenges will require that a quality product needs to be developed at an accelerated pace and in the absence or abbreviation of several key steps in the accepted materials development process.

As there is also limited availability of syphilis-technical and competency based training expertise among full time local project staff, IEC TA for development of clinic training and counselling materials should have dual technical competency in those areas, to overlay those skills with those of the project team.

4. Reschedule In-Country IEC TA to Accommodate Other Project Activities

Local project staff currently have a full schedule completing clinic based training in the ten project sites which will carry

them through to early December. Therefore, senior project staff do not recommend external IEC TA until initial clinic training has been completed. During this IEC TA visit, enough pre-planning of the next phase of IEC activities (development of messages and materials based on research results) took place to assure timely completion of draft materials prior to refresher training (mid-February 93) even if initiated in mid-January.

Additional on-site external IEC TA should therefore be delayed until January 1993, when a team of two external consultants, one for counselling training and module development and one for IEC message and materials development, should overlap.

Considering all of the above, the remaining IEC TA should therefore be rescheduled as follows:

<u>October 1 - November 15, 1992: Formative research TA in Kenya</u>

Qualitative Research Coordinator (Dr. Donna Klumpp tentatively identified): approximately 20 days;

<u>November/December 1992: IEC TA in Washington D.C.</u>

Approximately two-three weeks for training module design (e.g., counseling, standards of practice, use of IEC print materials) and preliminary message design (this consultant, or to be identified);

<u>January - February 1993: IEC TA in Kenya</u>

IEC Messages/Materials Design/both clinic and community levels, 6 weeks, or as recommended by the project team (consultant should have syphilis-specific technical knowledge and training skills);

Counselling Module Development/Training, 3 weeks (Pamela Greene tentatively identified);

<u>Additional follow-up IEC TA in Kenya only if requested by project staff.</u>

5. Rely More on Existing Materials, Information, and Stress Integration with Other STD Program Activities in the IEC Materials Development for this Project

Although a large amount of the technical and sociocultural literature on syphilis and related STDs in women in developing countries was reviewed by the consultant prior to this assignment, this TA visit did not allow time for the systematic written documentation of the information contained in this literature and additional materials gathered in Kenya. This documentation of

existing information is customarily a key initial activity prior to qualitative research design.

The deletion of this important step may adversely influence availability and continuity of information required for maximum effectiveness of final research report preparation, and more importantly, of message design if it becomes necessary to switch consultants. If possible, MotherCare should support reinstitution of this activity as part of the final research report preparation; it represents another opportunity to contribute to the literature on women and syphilis in developing countries.

6. Develop Realistic, Task-Oriented Training and Materials

This project will develop systems and materials specifically for ten project-supported clinics within the larger NCC clinic system. These ten clinics receive levels of training, logistics and other support which may not be easily replicable in other areas of Nairobi or Kenya without continued donor support, given the current difficulties being experienced by NCC and MOH in Kenya. Therefore, IEC and other interventions should be developed considering constraints existing in the 44 non-project supported NCC clinics, and in the public health system throughout Kenya, to maximize use of the materials, future effectiveness of antenatal syphilis screening, and the possibility of replication without such extensive external support.

Perhaps the best example of this is that the average time available for post-diagnosis syphilis counselling at project and other NCC clinics is 3 -5 minutes. At STC Casino, where the majority of STD cases in Nairobi are and will continue to be seen in near future, the average time per client is 90 seconds.

Education and counselling training and materials developed by this project should therefore be realistic, competency based and task-oriented; the content of IEC materials should reflect the actual time available for clinic staff to use them, and contain only the key learning points required for both clients and providers.

7. Continue to Seek Additional Resources/Opportunities to Conduct Qualitative Research on STD Related Topics of the Larger Scope and More Comprehensive Content Originally Planned

This small project on antenatal syphilis screening is housed at the WHO STD Research Centre at the University of Nairobi/ Kenyatta Hospital, where a multitude of STD clinical research and other STD related activities are in progress. Senior project staff who provide part time technical supervision and expertise for this project are also key personnel in many of these other studies, funded by CIDA, the EEC and other donors.

The role, methodology and potential contribution of well-designed qualitative research in refining the design and improving the effectiveness of STD programs was the subject of many lengthy discussions with senior project staff during this TA visit, both formally and informally. The clinical study recently completed by Dr. Jenniskens at STC Casino demonstrated that half of STD patients seen there did not seek formal care until at least two weeks after the onset of symptoms; one fourth of STD patients waited over a month before seeking treatment at STC, and the compliance rate with recommended follow up examinations for test-of-cure is low. (The emerging understanding of the role of genital ulcerative disease (GUD) in increased HIV transmission necessitates the earliest possible diagnosis and treatment of STDs; in the case of syphilis, the ulcerative phase occurs at average of three weeks post exposure.) Another study of STD care use in Nairobi by Dr. Moses published in a recent issue of LANCET (August 22, p. 465) states that "we have no clear knowledge of the many factors that influence decisions about seeking care for STD's ...in Kenya".

Perhaps as much as any other single MotherCare-funded project to date, this small study potentially allowed the opportunity to concurrently investigate and document the issues of maternal health care seeking behavior (antenatal care attendance), compliance with treatment recommendations, and with referral for additional care (partner notification and treatment and postpartum nnewborn exam); all of which are important components of the maternal and neonatal behavior change frameworks developed by this consultant and the Manoff Group during the first years of the MotherCare project. If the revised design and budget for this project now under discussion favors shifting available project funds to reinstitute the original project objective for provision of pregnancy outcome data, and further reduces IEC monies available, MotherCare will have lost a valuable opportunity to directly add to available knowledge on these critical maternal health care behavioral issues.

However, it may be possible for senior project staff of the syphilis screening project to allocate funds from the various related projects to support an investigation of the factors influencing STD healthcare-seeking behavior of both women and their partners.

8. Modify Future IEC Technical Assistance to Allow More Time for Discussion of Factors Required to Support the IEC Component of Operations or Clinical Research Projects

According to the project team, communication between MotherCare and project staff could have been increased during the proposal revision process. Although drafts of the project proposal were reviewed and approved by the project team before its official approval by USAID, the project team felt that the revised project

design could have better reflected local project needs and priorities, since the project team and its strengths are based in clinical research. Additional in-depth discussions (perhaps even an orientation workshop) on the theory and implementation of IEC campaigns and the need to plan for substantial technical staffing, considerable program time and attention, and appropriate budgetary considerations would have been very useful to prepare the project team for such a project after their approval of it.

VI. Follow-up Required

By Local Project Staff:

- Local project staff will continue work according to the new job descriptions, and the roles, responsibilities, and schedule developed during the final days of this visit;

- Coordinate the orientation and initial research planning activities of the consultant qualitative research coordinator who is now scheduled to begin work approximately October 1;

- PATH STD IEC materials should be purchased for use in the project clinics at the end of September, or as soon as they become available;

- Assure that in addition to the other supplies provided by the project, condoms are available at or provided to projects clinics (consult with senior project staff to determine most convenient, reliable source);

By the tentatively identified Qualitative Research Coordinator (QRC):

- Proceed, according to terms defined in the revised scope of work which will be prepared by The Manoff Group/MotherCare project after budget review is completed, to coordinate and implement the research, translate and analyze the results, and prepare a preliminary analysis of research results for submission to MotherCare;

By MotherCare/Manoff:

- MotherCare will need to make immediate provision for development of the revised research plan and detailed question guides, to be supplied to the in-country research coordinator;

- With the Project team, contact Emanuel Kariuki, the tentatively identified artist/graphic designer for this project's IEC materials, in Nairobi to contract him for the required period in January 1993. Failure to book him now may require use of another artist who does not have his experience and exposure to STD materials design and pretesting, and would therefore require more staff time to brief;

By the MotherCare IEC Consultant:

- o Provide additional assistance and Washington-based oversight of the IEC component of the project, if required, potentially including:

  --development of the revised research plan and detailed question guides for the qualitative research;
  --develop prototype training modules and counseling print materials for review, adaptation and adoption in Kenya.

Appendix A: List of Contacts

Dr Stephen Moses/Dr Elizabeth Ngugi ,Co-Directors
Department of Community Health
University of Nairobi/University of Manitoba STD Project
WHO STD Research Centre, Kenyatta Hospital
Nairobi
office phone 714 851

Dr. Marlene Temmerman, former Project Director
University hospital Gent
De Pintelaan 185
B9000 Gent - Belgium
32 91 403783 fax 404972

Dr. Francoise Jeniskens, Current Project Director
Dr. Emily Obwaka, Field Coordinator 726300 x43360
Mrs. Sarah Kirisua, Counselling Coordinator
Mr. Michael Kitabu, Laboratory Technician

MotherCare Preventing Congenital Syphilis Project at
Department of Medical Microbiology/ WHO STD Research Centre
Kenyatta Hospital

Ms. Mildred Howard
USAID
PO Box 30261 Nairobi
331160

Emmanuel Kariuki
Artist/Graphic Designer (working with PATH on STD materials)
Central Arts Promotion
PO Box 8364
Nairobi
tel 332146

George Kahuthia/ Lorna Nganga
PATH
30 Ole odume Rd
PO Box 76634
Nairobi
tel 569331 569375 fax 566714

Dr. Fatima Muhamadali
Nairobi City Commission Department of Public Health
Nairobi

Dr. David Alnwick, Chief, Health and Nutrition
Mr. Carlton James, Senior Information Officer
Caroline Blair, AIDS Project
Grace Siongo, Education Officer
UNICEF
Nairobi

520600

David and Sharon Wilkinson
Innovative Communication Systems
Nairobi
tel 564682

Dr. Sherry Guild, Regional Technical Advisor
CARE
Nairobi
724674

Dr. Donna Klumpp, Anthropolgist
Kariokor, Nairobi
760078

Mr. Nicholas Dondi, IEC Consultant
PO Box 74070
Nairobi

Luis Kimani Gatonye
PO Box 23304
02 592434
Cartoonist

Alice Liambila
T Shirts/Kanga Printing
02 630 796

Appendix B: Report of Initial Screening/Treatment Data from 3 Project Clinics

clinic	Total No of antenatals seen	No RPR Tests done	No. +ves RPRS	No. of +ves Treated	No. of partners notified ★	No. of partners Treated	% +ves	Quality control			comments
								+ves at UOM.lab	+ves at clinic lab	False -ves	
DANDORA H/C (29/6/92-12/8/92)	471	471	27	27	27	13	5.7%				Bigger CIDA project on strengthening STD. control set up affords better counselling fairly good partner compliance 48%
LANGATA H/C (30/7/92-12/8/92)	92	92	11	6	10	1	11.95	9	11	0	Low No.of +ves treated as results of lack of syringes. -No proper counselling see up-> low compliance partners.
KARIOBANGI H/C (10/7/92-10/8/92)	360	360	27	27	27	24	7.4%	19	23	0	-Two of those which were +ve at clinic Lab. but -ve at med.m. Lab. where weakly positive when confirmatory test was done. -High partner compliance as Nurse withhold antenatal card until partner comes for treatment.

★ "PARTNER NOTIFICATION" ACCORDING TO DEFINITION PRIOR TO THIS TA VISIT – ACTUALLY SIGNIFIES THAT RPR+ WOMAN WAS INFORMED OF N: TO NOTIFY PARTNER.

M.M.

Appendix C: Revised Project Workplan

(DRAFT) REVISED WORKPLAN - ANTENATAL SYPHILIS SCREENING PROJECT / KENYA

CTIVITY	JUNE	JULY	AUGUST	SEPT	OCT	NOV	DEC	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUGUST
HIRE & TRAIN PROJ STAFF	X	X													
ESELINE DATA COLLECTION (2 WKS/CLINIC)		X	X	X	X										
ITIAL RPR & AINING CLINIC (2 WKS/CLINIC) EFF (10 CLINICS) CREENING, TREATMENT, COUNSELLING)		X	X	X	X	X	X								
UALITATIVE RESEARCH ~~RESEARCH~~ DESIGN IMPLEMENTATION			X												
RAFT ESSAGE & MATERIALS DESIGN				X	X	X									
PRETEST DRAFT MATERIALS AT							X	X							
EFRESHER TRAINING IEC + COUNSELLING CLINIC STAFF								X	X						
INAL MATERIALS/LAUNCH									X						
EVELOP COMMUNITY COMPONENT (FRAMEWORK)									X						
ELOP TEST COMMUNITY MATERIALS										X	X				
											X	X	X		
VALUATION														X	

Appendix D: Draft Management Information System.

MANAGEMENT INFORMATION SYSTEM

PROJECT OBJECTIVES	TARGET		INFORMATION REQUIRED	HOW WHERE RECORDED	INITIALLY RECORDED BY (CLINIC STAFF)	HOW OFTEN COLLECTED	COLLECTED BY (PROJECT STAFF)	INDICATORS SUCCESS
INTERVENTION OBJECTIVES:	%	%						
1. To increase early use of prenatal care (before 20 weeks gestation)	25	80	Total # antenatals # early antenatals # late antenatals	antenatal cards	recorded on ANC card	daily		
2. Increase screening of pregnant women for syphilis	50	90	Total #antenatals # RPR's performed # RPR recorded on pt. antenatal card	clinic records RPR logbook lab book in PMH	results from PMH all sent to the clinics on daily basis	daily	Eunice/emily	
3. Improve treatment of pregnant women identified RPR(+)	30	100	# RPR(+) women detected # RPR(+) women treated	ANC		monthly	Eunice/Emily	
4. Increase partner notification/patner treatment			# advised to notify partner # partners report to clinic				Eunine/Emily	partner treatment

PROJECT OBJECTIVES	TARGET	INFORMATION REQUIRED	HOW/WHERE RECORDED	INITIALLY RECORDED BY CLINIC (CLINIC STAFF)	HOW OFTEN COLLECTED	COLLECTED BY (PROJECT STAFF)	INDICATORS ~~BUDUCTIONS~~ OF SUCCESS
RESEARCH							
OBJECTIVES							
1 Study Syphilis transmission Outcome stillbirths (maternal fetal)by gestational age at treatment		# of newborns/infants with: -congenital syphilis -stillbirth Timing of retreatment in pregnancy(#wks gestation) # identical treated/timings -Partners treated -Outcome stillbirths conp syphilis -gestage at rx. gestational				Emily/Njoga	
2 Determine cost/benefit of repeat RPR in 3rd ???		# early attenders who return for 3rd tri repeat RPR					
3 Examine cost effectiveness feasibility of proposed interventions							

PROJECT OBJECTIVES	TARGET	INFORMATION REQUIRED	HOW WHERE RECORDED	INITIALLY RECORDED BY (CLINIC STAFF)	HOW OFTEN COLLECTED	COLLECTED BY (PROJECT STAFF)	INDICATOR ~~DUBUGTIONS~~ SUCCESS
BEHAVIORAL OBJECTIVES	% %						
Pregnant women							
1. early antenatal attendance (prior to 20 months)		# antenatals visits # early/late antenatal					
2. For early attenders, comply with F/U visit for repeat RPR 28 weeks.		# early attenders # who kept 28 wk per visit					
3 Notify partner and negotiate partner compliance with treatment visit		partners notified by women of RPR(+) status/need for F/U # partners agree condom use/actual use					
4.Comply with postpartum newborn screening RPR		# newborns RPR(+)					

PROJECT OBJECTIVES	TARGET	INFORMATION REQUIRED	HOW WHERE RECORDED	INITIALLY RECORDED BY (CLINIC STAFF)	HOW OFTEN COLLECTED	COLLECTED BY (PROJECT STAFF)	~~INDUCTIONS~~ SUCCESS
HEALTH WORKERS	% %						
1 Facilitate early antenatal care attendance							
2 Improved diagnostic/treament skills		# cases maternal syphilis diagnosed # cases maternal syphilis correctly treated # knowledge one or more signs syphilis etc...	antenatal clinic record RPR(+) logbook pre/postsparainterview				
3 Improved counselling skills -components of counselling delivered -conselling attitude		# women receive complete syphilis counselling -implications of diagnosis -treatment required -need for partner rx					
4 Increased participation in partner tracing and treatment Promote condom use to prevent infection		# partners notified by RPR women, partners attend clinic for rx, partners con?? rx # condoms dispensed to partners with complete counselling in use					
5 Improved record keeping skills/ performance							
6 encourage return visit 3rd trimester RPR screen in early attenders give date for return visit		#postpartum visits					

PROJECT OBJECTIVES	TARGET	INFORMATION REQUIRED	HOW WHERE RECORDED	INITIALLY RECORDED BY (CLINIC STAFF)	HOW OFTEN COLLECTED	COLLECTED BY ~~(PROJECT STAFF)~~	~~DUDUCTIONS~~ SUCCESS
BEHAVIORAL OBJECTIVES:	% %						
Male partners							
1.Comply with partners treatment visit request		# partners attend clinic and treated correctly # know need to use condoms # used condoms					
2.Use condoms to prevent reinfection (especially with extramarital contacts)							
3.Adopt other suggested 'play safe' behaviours limit partners women identified RPR(+)		# knowledge of 1 or more prevention behavior # trail of prevention behaviour # adopt prevention behaviour					
4.Support early antenatal care attendance for partner and others							

PROJECT OBJECTIVES	TARGET		INFORMATION REQUIRED	HOW WHERE RECORDED	INITIALLY RECORDED BY (CLINIC STAFF)	HOW OFTEN COLLECTED	COLLECTED BY ~~(PROJECT STAFF)~~	~~DUDUCTIONS~~ SUCCESS
CBHW	%	%						
1.Recognise and refer potential STD symptoms in community								
2.paticipate in contact tracing								
3.Promote condom use/distribute condoms								
4.Provide quality, primary level syphilis prevention educaton								

Appendix E: Guidelines for Clinic-Based Syphilis Education/ Counselling Content

8/16 mona moore for Sarah

possible health ed/counselling topics for developing clinic-based preventing congenital syphilis activities

Health Education (delivered while antenatals are in waiting room)

should contain:

- how common syphilis is in pregnant women/ newborns in kenya?
- risky practices/ high risk groups for syphilis transmission
- signs and symptoms of syphilis early/late (especially chancre)
- health consequences of syphilis for pregnant women, newborns, men
- need for laboratory (blood) test to screen for syphilis in pregnancy
- briefly, other ulcerative STD (chancroid, herpes) and link to AIDS prevention/transmission
- methods of preventing syphilis/STDs
  - condom use
  - limiting sexual partners
- need for partner involvement in STD prevention during pregnancy
- benefits of early antenatal attendance in preventing syphilis, and other benefits
- common barriers women face in trying/adopting recommended preventive behaviors
- condoms provided?

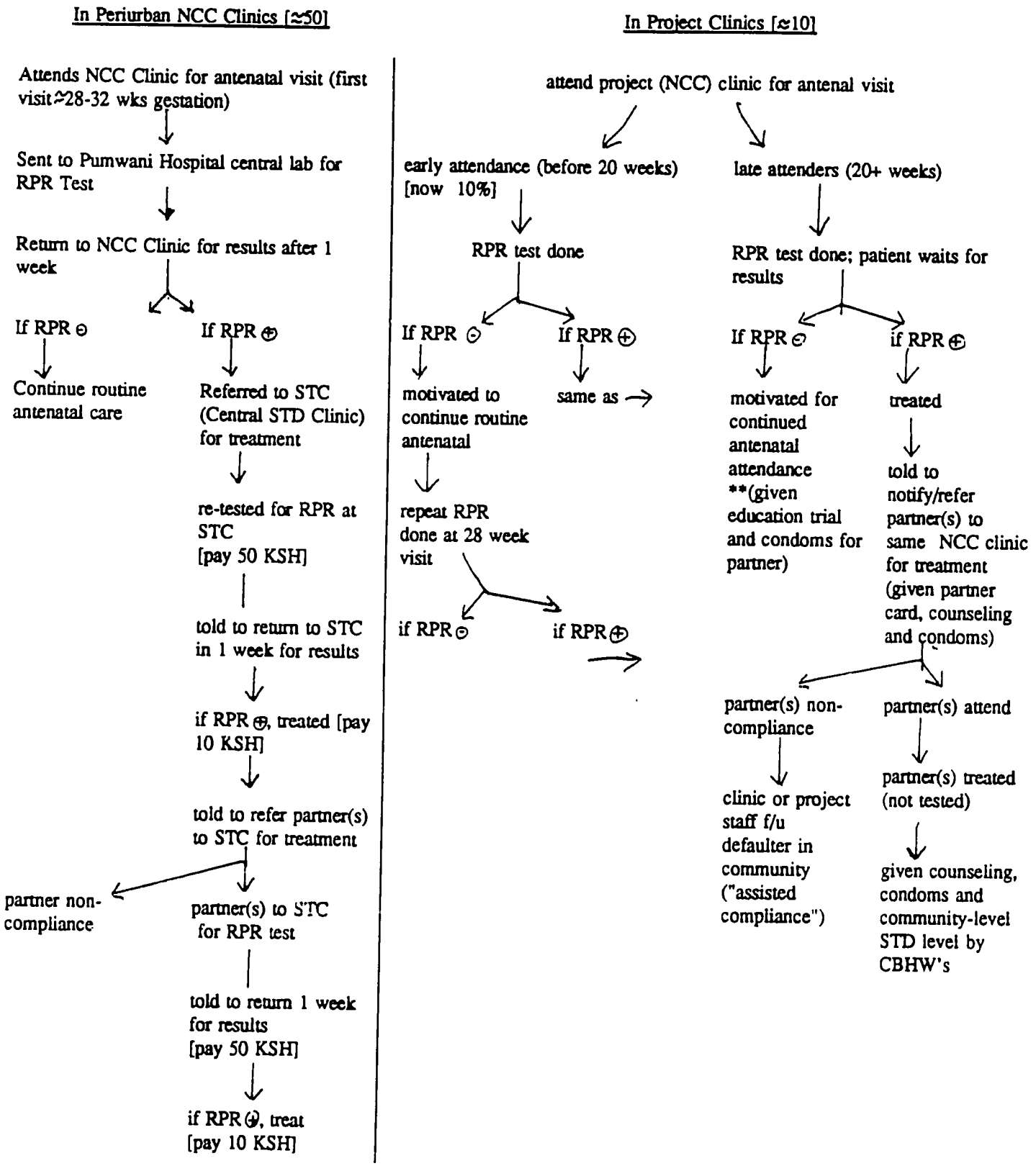
Counselling of RPR positive antenatals, post treatment

o meaning of positive laboratory (blood) test to screen for syphilis in pregnancy
o health consequences of syphilis for pregnant women, newborns, men if untreated
o treatment required
o need for partner(s) treatment, role of partner in STD prevention of reinfection during pregnancy
o brief sexual history/practices to determine # partners, risk category
o methods of preventing syphilis/STDs
    condom use
    limiting sexual partners
o possible barriers to getting partner treated, and ways to motivate him/them to seek/accept treatment

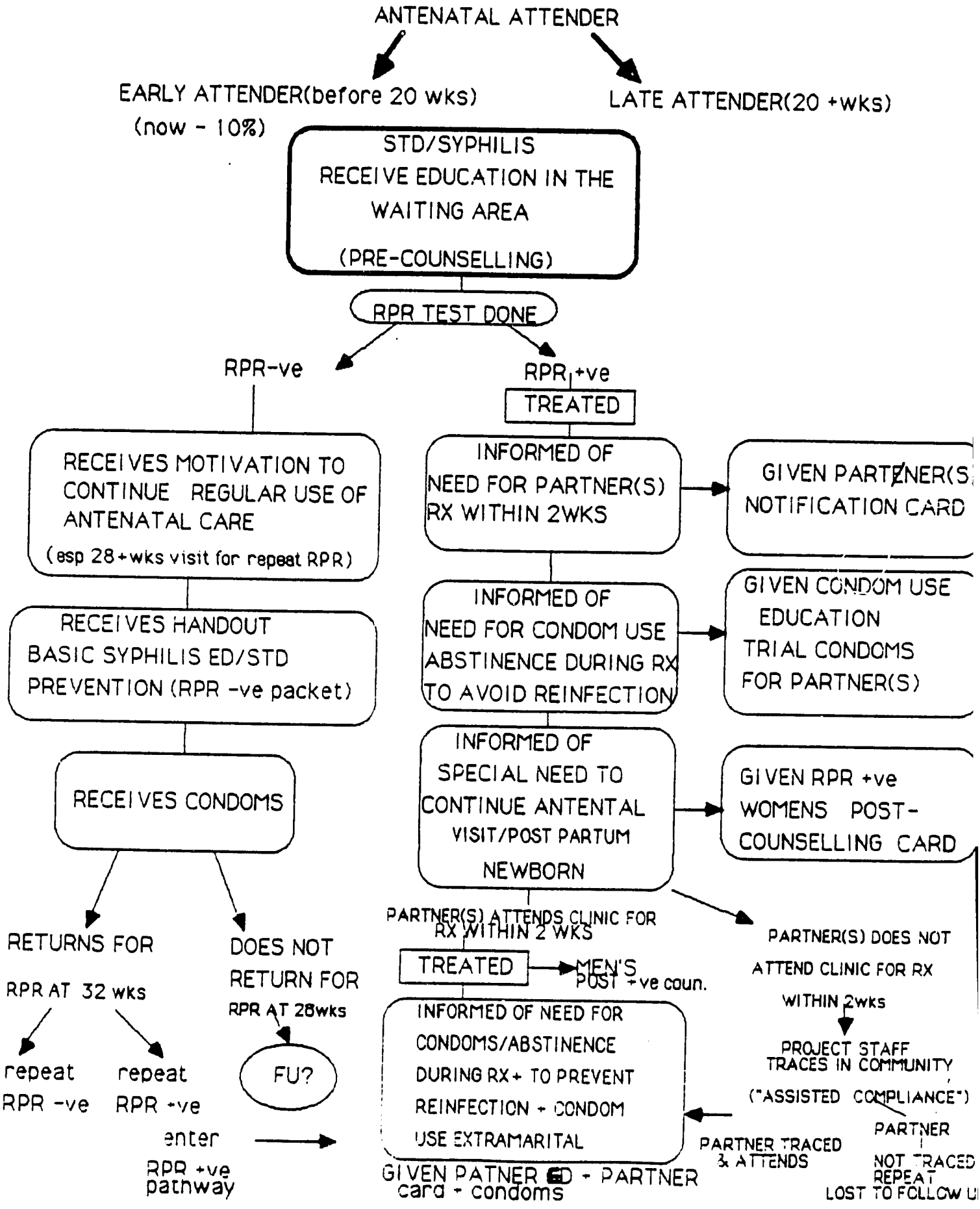
o recognizing/discussing with partner
    - the signs and symptoms of syphilis early/late (especially chancre)
    - link between treatment of syphilis and
        1) AIDS prevention/transmission
        2) complications in pregnancy - miscarriage, stillbirth, prematurity- and in newborn- congenital malformations (facial, bone formation), deafness,
o common barriers women face in convincing partner to try/adopt recommended syphilis/STD preventive behaviors (use condoms or limit partners to prevent reinfection during and after pregnancy)
o condoms distributed?
o need for continued antenatal attendance to monitor course of pregnancy
o need for postpartum screening test for newborn/where and how to obtain
o distribute RPR positive action card for the pregnant woman (reminder of key counselling points), partner notification card and partner education sheet

Appendix F: Flowcharts of Syphilis Treatment/Education Provided by NCC and "Decentralized" Project Clinics

Pathway for Syphilis Screening in Pregnancy
Nairobi, Kenya



PATHWAY FOR SYPHILIS SCREENING IN PREGNANCY



Appendix G: Social Marketing Workplan

STEP	TIME REQ'D/ DATES	MARCH	JULY 92	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MARCH	APRIL	MAY	JUNE 93	Technical Assistance
1. DEVELOP SOCIAL MARKETING PLAN Objectives, Strategies, Resources, Budget, Time frame	2 week (pre-project)	X													
2. CONDUCT FORMATIVE RESEARCH	weeks														
- Develop qualitative research plan - protocols & instruments				X											X AUG 92 MOTHERCARE/ MONA MOORE
- Develop scope of work for local consultant				X											
- Select consultant, brief				X	X										
- Train staff	8 WEEKS				X	X									
- Pretest interview guides					X	X									
- Conduct research						X	X								
- Translate & organize results						X	X								
3. ANALYZE RESULTS & WRITE REPORT AND STRATEGY WORKSHOP	4 weeks						X	X							X NOVEMBER 92 MOTHERCARE/
4. DESIGN COMMUNICATION PLAN - Define target audiences, messages, channels	4 weeks						X	X							
5. DEVELOP DRAFT MESSAGES AND MATERIALS FOR EACH MEDIA	4 WEEKS							X	X						
6. PRETEST MESSAGES AND MATERIALS	4 weeks														
- Design pretest protocol and instruments															JANUARY 93
- Train staff										X					X MOTHERCARE
- Conduct pretest AT CLINIC STAFF REFRESHER TRAINING										X					
- Analyze results										X					
- TRAIN USERS OF MATERIALS										X					
7. REVISE MESSAGES											X				
8. PRODUCE FINAL MATERIALS/AND FINAL MEDIA PLAN	8 WEEKS										X	X			
LAUNCH (IMPLEMENTATION)	ongoing													X	

Appendix H: Recommended Behaviors for Target Groups

Recommended Behaviors for Syphilis Control in Pregnancy Project

Pregnant Women

o early antenatal attendance
o return to clinic for RPR results (if not obtained at project clinic)
o seek/accept treatment if RPR positive
o attend counselling and comply with recommendations for:
  - treatment regimen
- follow up visit third trimester for repeat RPR
- postpartum visit for infant RPR serology
- participate in contact tracing (notify partner of need for partner treatment) and encourage partner compliance

Men/Partners

o comply with partner treatment request
o use condom post treatment to prevent reinfection from extramarital partners
o support early antenatal care for pregant partner; and return visit third trimester for repeat RPR in positive women

Antenatal/STD Health Workers

o encourage early antenatal attendance
o assist in provision of quality comprehensive STD treatment and antenatal care
  - improved recognition, diagnosis and treatment
  - demonstrate supportive attitude to RPR positive women
  - provide sympathetic, complete STD/syphilis counselling
  - increased attention to contact tracing and partner treatment, including follow up of defaulters (give patient the project partner notification card)
  - encourage return visit for repeat RPR in third trimester (give patient specific date and project return screening appointment/reminder card)
  - keep accurate and complete records of antenatal and RPR positive patients, partner treatment, return visit compliance for project management information system and better clinic performance in STD prevention

Influentials (Family, Community)

Policy Makers

CBHW's.
• provide quality primary level syphilis prevention education
• recognize & refer potential STD Sx.
• [illegible]

Appendix I: Original Qualitative Research Plan Containing "Menu" of Topic Areas for STD Research

mona moore nairobi 10/8/92

Opportunities to Improve Maternal and Child Health: Syphilis Control in Pregnancy Project

2nd DRAFT FOR STAFF COMMENT

Qualitative research objectives

o to document the current level of knowledge/awareness, beliefs/attitudes, practices/behaviors of pregnant women, their partners and family influentials,toward syphilis and to a lesser degree, related STDs.

o to identify factors influencing current patterns of health care seeking behavior of pregnant women, especially late use of formal public sector maternal care; possible motivating factors for earlier use of antenatal care

o to explore with women and men who have successfully/unsuccessfully completed treatment for syphilis, especially women who are/were RPR positive during pregnancy and their partners, the factors which influenced their compliance with treatment and referral recommendations

o to investigate behavioral, attitudinal, technical skill/knowledge and other factors which influence quality of care antenatal/STD provision by clinic based and community based health workers

STD policymakers?

Suggested topic areas for qualitative research:

Pregnant women: antenatal care users (early/late), non-users, young primips?

Factors influencing antenatal care use

- emotional response to pregnancy (planned? wanted?)
- understanding of need for/benefits of antenatal care,
- knowledge of content of antenatal care
- current/past use of antenatal care - formal, informal, self care (pregnancy health seeking behavior)
- reasons for seeking care; most valued component of care
- expectations of care/definition of treatment success or failure
- preference for maternal care source and care provider
- previous experience with public sector maternal care
- perceived value of preventive care
- perceived consequences/dangers of non use of care during pregancy/postpartum
- barriers/resistances to seeking care
- what do women themselves think would motivate them and other women to use antenatal care early?

- knowledge of medical risks and problems of antepartum, intrapartum and postpartum periods * specifically knowledge and perceived causes of syphilis/STD related problems of pregnancy and newborn (stillbirth, miscarriage, prematurity, congenital deformities, deafness, etc)
- knowledge of historical pregnancy risks (primaparity, grand multiparity, age over 35, etc)
- recognition of danger signs in pregnancy
- triggers to health seeking action during pregnancy

- current problems in pregnancy, medical or other concerns
- role of influential/social support givers in antenatal care use decisionmaking
- choice of childbirth location/ birth attendant and reasons

KABP of Syphilis/STDs among pregnant women, men, community

- awareness of prevalence of syphilis in Kenya/Nairobi
- ethnomedical categorization of syphilis/STDs as type of disease
- understanding of mode of transmission of syphilis
- knowledge of symptoms of syphilis/STDs
- perceived severity of syphilis, knowledge of possible sequelae
- awareness of possible infection with syphilis among

pregnant/women, newborns and consequences/sequelae

- awareness of relationship between syphilis and other ulcerative STDs and AIDS transmission
- awareness of methods of syphilis/STD prevention
- awareness of possibility and means of reinfection after successful treatment during pregnancy - need for partner treatment ,condom use

- knowledge of syphilis/STD risk factors/groups
- perceived personal risk (personal suceptibility)
- personal experience with syphilis/STDs - self, partner, friend
- STD related health seeking behavior - types of care sought/ timing, source, practitioner,compliance, percieved need for and efficacy of treatment (heirarchy of resort)

- attitudes toward bloodletting, injections, pill swallowing
- anticipated consequences of non- use of STD treatment

Sexual Communication and STD/Antenatal Care Information Sources

- identify influentials/decisionmakers for health care use in pregnancy/STDs
- "comfort level" of communication about pregnancy/sexual matters/STDs with partner, family, friends, health professionals; barriers to talking about sex/sexual health/STDs/STD prevention in the home, family and community

- current sources of pregnancy/sexual/STD information; preferred sources
- reliability/credibility of information sources
- pregnancy/STD information needs of women/men

Sexual Practice/Experience/Networking

- sexual norms, taboos/restrictions/traditional beliefs which can influence STD transmission *, especially beliefs about sex and pregnancy
- expectations of marriage/relationships/sex (monogamy, extramarital sex/effects of long periods of separation)
    - "sexual survival" - degree of need/practice to trade sex for compensation (monetary or other)

- sexual history

    o age at first sexual encounter/intercourse
    o number of partners week/month/year

o ID partner - spouse, regular partner, friend/neighbor, co worker, casual date, paid sex other)
o total number partners lifetime
o number of times intercourse week/month/year
o rate of partner change
o types of sexual activity (anal intercourse, homosexual/bisexual, other risk behaviors associated with STDs)

(can create "typology" by sexual practice - frequency, types and rate of change of partner, types of practice- For our research, this can be important in reducing stigma - for the most part our RPR positive antenatals are not sexual deviants!)

- use of topical or intravaginal agents which might influence STD transmission (herbs, powders, cloth, others, when, why how, frequency)
- frequency of risky behaviors (unprotected sex, sex with unknown partner, etc)
- "female problems" current/past experience with STDs, other common medical problems exclusive to women - vaginal discharge, pregnancy/childbirth related complaints, VVF, UTIs, etc

- substance abuse (alcohol, others) and effects on sexual behavior (self, partner) "disinhibition"

Self Esteem/ Locus of Control/ Psycosocial Factors

- level of perceived control over personal health : reproductive health
- perception among women of ability to act on STD messages
  o ability to influence type of sexual encounter/partner
  o ability to "negotiate" with sexual partner(s) re condom use, compliance with partner treatment recommendation, sexual habits, avoidance of reinfection, alcohol use etc.

- fatalism
- blame/responsibility
- shame/stigma/ vulnerability, fears (of retaliation, aversion, abandonment, other consequences of revealing infection with STD to partner/family)
- fear, worry, level of personal concern about STDs
- denial

- explore strategies women themselves think might be successful to overcome resistances to STD preventive behavior change by men

- can/will women buy, introduce idea of use of condom to partner? do women know how/are willing to apply condom?

* Examples from literature of sexual beliefs which can influence STD transmission

- receiving sperm during pregnancy has beneficial effects on mother and fetus (Zaire, Papua New Guinea)
- use of intravaginal agents to increase sexual pleasure for partner (East Africa, Asia)
- coitus interruptus reduces/eliminates STD transmission (Zaire)
- STDs are "spiritual origin", can be treated only by traditional practitioners (Swaziland)
- younger women/girls less likely to have STDs, seek younger partners or virgins (West Africa)
- having sex with virgin can cure STD (by "transfer" of infection)
- anal sex seen as viable/preferred alternative if infected with STD - therefore not passing infction to partner (Brazil, Latin America)

MEN/MALE PARTNERS of STD PATIENTS:

version of above questioning, plus:

- aware of potential of STD prevention through condom use? ever use? why, why not? (intended versus actual use)
- degree of change in sexual behavior due to STD knowledge? which? why, why not?
- what conditions would increase acceptability of condom use/ compliance with partner treatment?
- what would motivate men to encourage/support early use of antenatal care among their partners?

STD and Antenatal Health Workers

- knowledge of syphilis

  o national prevalence in men, pregnant women, newborns/children
  o risk factors/groups
  o know and recognize symptoms of syphilis, other STDs in men, women, newborns, children; phases of syphilis, symptom progression per phase
  o know and recognize sequelae/consequences of syphilis in pregnant women, newborns/children
  o diagnosis of syphilis, differential diagnosis between syphilis and other ulcerative STDs
  o lab diagnosis, confirmatory, RPR vs FTA etc, need for and timing of repeat testing
  o treatment recommendations, dosage, timing, differences between types and route of administration of penicillin; different treatment requirements per stage of syphilis, effectiveness of treatment per phase; importance of early intervention

- awareness of possibility of reinfection; need for and timing of repeat RPR screening during pregnancy; need for postpartum screening of infant

- awareness of relationship between ulcerative STDs and increased AIDS transmission; importance of STD prevention as AIDS control measure

- understanding of barriers women face seeking STD care/treatment

- ID barriers providers face when caring for STD patients

- attitudes toward STD patients/ antenatal patients in general ("labelling", stereotypes, stigma)

- awareness of need for and attitude toward early vs late antenatal care attendance

- what comprises quality, comprehensive STD treatment?

- awareness of need for, content of STD counselling; perceived role, responsibility for, skill at delivering (nature of infection and treatment requirements, effects of syphilis on mother and child, importance of partner notification and treatment, recheck in third trimester, postpartum infant screening, condom use to prevent reinfection, benefits of early prenatal care)

- awareness of importance of and attitude toward contact/partner tracing and treatment; perceived role, responsibility for, skill/ability to do

- attitude toward condom promotion/use for STD prevention

- attitude toward, role and responsibility for encouraging repeat RPR screening in late pregnancy

- ID barriers to provision of each component of STD care

- perceptions of sexual practices of patients/preventive efforts of patients

- support possibility to educate women/change STD related behavior through clinic based education? what other methods might be effective?

COMMUNICATION CHANNELS

VERBATIMS/ KEY WORDS/ CASE HISTORIES

Appendix J: Revised Job Description/Counselling Coordinator

Revised Job Description for SARAH

Counselling/ Community Education Coordinator

In close collaboration with field coordinator and IEC coordinator will:

o develop an antenatal syphilis prevention education session for clinic attenders and a counselling session for RPR positive women, according to content guidelines developed by project staff; and a clinic counselling/education implementation plan

o participate in assessment of baseline quality of clinic syphilis prevention education/counselling; visit each project clinic at least once monthly to perform routine and periodic interim assessments and assist clinic staff with counselling/education problems

o perform initial clinic staff training in syphilis education/counselling as part of and according to overall project training schedule

o assist with the development and implementation of partner tracing and treatment activities, especially community based component

o assist with qualitative research interviews and process as time allows, especially CBHWs, pregnant woman and RPR positive women

after completion of initial clinic training:

o assist in development of counselling education IEC materials, and in refresher training counselling/education session for clinic staff

o be primarily responsible for identification and documentation of current and potential clinic/community education linkages, with assistance from project staff as required

o assist in development of CBHW counselling/education assessment, project community level education activities and materials for CBHW level syphilis prevention/early antenatal attendance motivation

Appendix K: Training Protocols for Project Clinic Staff

MOTHERCARE PROJECT PROTOCOL FOR SYPHILIS SCREENING IN PREGNANCY

Baseline will be carried out to ascertain the percentage of pregnant women screened for syphilis at the target clinics, those that are treated having been found RPR positive and number of partners notified and treated. A record book will be set up in both the antenatal room and the clinic laboratory to collect information relevant to the objectives.

OBJECTIVES

1. To increase the proportion of pregnant women screened for syphilis at the antenatal clinics from 50% to 90%.

2. To raise the number of pregnant women receiving treatment when found to have syphilis antibodies, from 30% to 100%.

3. To increase the number of partners notified and treated.

4. To examine the potential benefit and cost of a second syphilis screening test in the third trimester of pregnancy.

METHODOLOGY

Registration of all antenatal patients that come from the catchment area served by the particular clinic will be done as is the policy of the City Commission. As registration is proceeding a health talk will be delivered by one of the nursing staff on STDs/Syphilis. The talk will cover the following scope:

- how common syphilis is in pregnant women / newborns in Kenya
- risky practises / high risk groups for syphilis transmission
- signs and symptoms of syphilis

- health consequences of pregnancy
- need for laboratory (blood) test to screen for syphilis
- it's relationship to AIDS
- methods of preventing syphilis /STDs
- need for partner involvement in STD prevention
- benefits of early antenatal attendance including preventing syphilis

All new antenatal patients will be bled and blood specim collected in the special red top tubes and needles design specially for syphilis investigations. Each specimen will ha details of the patient's name, clinic number and age. The RPR ca test used to test for presence of syphilis antibodies will performed on each specimen in the clinic laboratory. The te results in addition to details on the specimen tube plus t patient's gestational age will be recorded in a record book set in the lab. Any patient attending before 20 weeks who tes negative will have a yellow sticker placed on their card so as t alert the nurse dealing with patient that she will have a secor RPR test done at approximately 32 weeks. The results whethe negative or positive will be recorded on every patient's card an returned to the antenatal room. After routine antenata examination, each patient will be advised on their RPR result Those who are negative will be motivated to continue attendin clinic (once a month up to 32 weeks and weekly to delivery). Thos to have a repeat RPR test will be advised accordingly. Al 'negatives ' will receive some advice on danger signs associate with in pregnancy (particularly STDs) that should alert them t come to the clinic. A hand-out will be given containing informatior on basic syphilis/STD prevention. Condoms will also be given out

If an antenatal patient tests positive for syphilis antibodies (first or second test), she will be treated with 2.4 mu. Benzathine Penicillin give intramuscularly. She will then be counselled with the counselling covering the following scope:

- meaning of positive RPR test
- health consequences for the pregnant woman, newborn and men if untreated
- treatment required
- need for partner treatment / danger of reinfection (need for abstainace before partner treatment)
- methods of preventing syphilis (eg. condom use and limiting sexual partners)
- recognizing / discussing with partner
  - symptoms early/late syphilis
  - link between treatment of syphilis
  - AIDS prevention and transmission
  - complications in pregnancy associated with syphilis
- common barriers faced by women in trying to convince partners to come for treatment.
- need for continued antenatal attendance to monitor course of pregnancy
- need for postpartum screening test for the newborn and regular follow up there after

After counselling the patient will be given a positive action card with a remainder of key counselling points, a partner notification card and a patient education sheet.

A record book set up in the antenatal room will record details of every patient tested for syphilis and treated given if positive.

The same record book will record whether notification to th partner was given and whether treatment was given.

With regard to partner contact, if a partner fails to retur spontaneously within a period of 2 weeks, a Community Health Worke attached to that clinic will be given the name and contact addres in order to make a home visit aimed at assisting compliance. So a comparison may be made later,those that return spontaneously wil be identified by having a blue mark against their name in th record book while those who have assisted compliance will have black mark place next to their name. On reporting to the clinic th partner will be treated with 2.4mu B.P., given similar counsel with regards to STDs/Syphilis prevention as that given to the partner and given some condoms with advice on where to get more.

Those partners that do not return spontaneously or when home followup is made will be declared lost to followup.

Comparision of the parameter percentages found at baseline will be made with those found at the end.

THE RPR TRAINING

AIM

To decentralise syphilis screening to various health centres by setting up a RPR laboratory and training personnel at the identified health centres to perform the RPR card test so that first time antenatal attenders can be screened and positive RPR treated.

OBJECTIVES

1. To set up the laboratory in suitable room equipping it with: 1 centrifuge, a shaker, 2 tables and 4 chairs and other accesory items.

2. To give a detailed training to identified personnel on how to perform the RPR card test with special emphasis on laboratory safety precautions.

3. To give a brief general introduction to basic councelling skills.

WORKING OBJECTIVES FOR THE RPR PROCEDURE AND CRITERIA BASED ASSESSMENT

1. That the trainees will be able to correctly record each patient's name clinic name and number, date each blood sample.

2. That the trainee will correctly load the samples onto t centifuge taking care to balance these.

3. That trainee will correctly replace the centrifuge cap a time the spinning time accurately.

4. That the trainee will correctly tranfer numbers on tl samples to the RPR card.

5. That the trainee will correctly withdraw serum and place drop onto the centre of e circle designated to it using dispenstir.

6. That the trainee will spread the serum drop using opposit side of the dispenstir and dispose of it after every sample

7. That the trainee will correctly squeeze one drop of th antigen onto each serum circle.

8. That the trainee will have have the card on the shaker for a sufficient amount of time with the humidifier in place.

9. That the trainee will correctly read the results: identifying te positives and negatives correctly.

10. That the trainees will correctly record the result found to the patient's card and to the record book in the lab.

TRAINING OUTLINE

1. Brief introduction on what syphilis is, the magnitude of the problem in Kenya and the purpose for the training.

2. Introduction to lab. set up and essential lab safety measures.

3. Practical demonstration on performing the RPR card test based on the working objectives.

4. Practical participation for each trainee.

5. Criteria based assessment on the working objectives.

Appendix L: Quality of Care at STC "Casino"

NOT FOR CIRCULATION OUTSIDE CORE MOTHERCARE STAFF

Care of Women with STDs at the Special Treatment Clinic (STC) in Nairobi, Kenya

By 7 A.M. the line has started forming outside the Special treatment Clinic (STC) in the outskirts of Nairobi, in a part of town rarely visited by the thousands of tourists and consultants who dominate other safer, more fashionable sections of the city. By the time the clinic staff begin to arrive a few hours later, the queue has swollen, winding around the streets nearby. By the end of the day, more than seven hundred men and women will have passed through the clinic gates seeking treatment for sexually transmitted diseases. Many have been referred from primary care clinics in periurban Nairobi, some as far as 15 kilometers away. Each patient pays 50 KSH for the exam, only about US $1.50, but higher than many people who need STD care can afford to pay. There are three clinical officers assigned to the STC, and between them, they must provide STD diagnosis, treatment and counselling for all those waiting to be seen.

Once inside, the men and women queue separately. At the entrance to the female exam area, a dozen or so of the approximately 350 women begin the well established routine. First, they must all remove their undergarments and shoes - which are piled at the entranceway- in order to be ready for the busy clinical officer when it is their turn. One at a time, they mount the bare examination table, around the corner, just outside the view of the others waiting.

There are no examination lamps, no paper or cloth on the examination table, and no one pauses to wipe the table between exams. The exam tables have no stirrups, and the legs of the woman dangle off the edge of the table, only her own kanga draped around her nakedness. Lack of windowcurtains exposes the woman to full view of those in the seedy lodging house/motel directly across the street. Whichever female staff member is available inserts the speculum in readiness for the clinical officer's exam - this could be the nurse assistant, clinic aide, or even the cleaner if she has a spare moment. Usually, the person who inserts the speculum also collects the swab for gonorrhea culture.

One of the three busy clinical officers, all of them male, sits briefly at the foot of the exam table, looks quickly at the presenting complaint of the woman as listed on her patient card, takes a cursory look into the speculum without any light source other than daylight to assist him and writes his diagnostic impressions and treatment on the womans card. No questions, no bimanual pelvic exam, no close inspection of the external genitalia. No discussion, no counselling, no explanation of the disease, its cause, its treatment. Sometimes the woman is told that her partner must come for treatment; sometimes not. Since there are three clinical officers and over seven hundred patients per day, the average time for service provision per patient is ninety seconds.

At the next station, the woman receives whatever medication(s) the clinical officer recommended, again with very little verbal exchange. For example, if the diagnosis is candidal vaginitis, fungicidal vaginal pessaries are distributed, but without any instructions on how or when to use them. Many of the STDs commonly diagnosed at STC are from multiple organisms, and are resistant to standard treatment regimens, requiring multiple drug therapy. The women must pay an additional 10 KSH per drug, often as much as 30 KSH, bringing the total cost of services at STC to 80 KSH, which for many is more than a days wage. If the drugs required are not in stock, the patient is given a prescription to fill at a commercial pharmacy, where the drugs are available, but much more costly.

By noontime, the queue has shortened. Those who waited several hours at the end of the line and were not given a patient number before they were all distributed are told to leave, and return again the following day to join at the front of the new day's queue.

* based on conversations with Dr Francoise Jenniskens, who has just completed a study of standards of clinical care for women with STDs at the STC.